Dental Program #3000

SAVE THIS BOOKLET FOR REFERENCE

This booklet explains benefit provisions that are specific to a dental plan administered by the Washington State Health Care Authority. This booklet, which explains program eligibility and general provisions, constitutes the certificate of coverage for enrollees in this dental plan. This certificate of coverage replaces and supersedes any and all previous certificates.

It is your responsibility to be informed about your benefits. To avoid penalty or loss of benefits, please note all plan preauthorization requirements, service area restrictions and benefit limitations. If provisions within this booklet are inconsistent with any federal or state statute or rules, the language of the statute or rule will have precedence over that contained in this publication.

This booklet was compiled by the Washington State Health Care Authority, 676 Woodland Square Loop S.E., P.O. Box 42682, Olympia, Washington 98504-2682. If you have questions on the provisions contained in this booklet, please contact the dental plan.

To obtain this publication in alternative format such as braille or audio, call our Americans with Disabilities Act (ADA) Coordinator at (360) 923-2805. TTY users please call 360-923-2701 or toll-free 1-888-923-5622.

UNIFORM DENTAL PLAN

Self-Insured by the State of Washington

FOR BENEFITS AVAILABLE BEGINNING JANUARY 1, 2003

Administered by
Washington Dental Service
P.O. Box 75688
Seattle, Washington 98125-0688
206-522-3344 or 1-800-537-3406
www.deltadentalwa.com

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UNIFORM DENTAL PLAN

Administered by Washington Dental Service

Welcome to the Uniform Dental Plan and Washington Dental Service (WDS). WDS began providing dental benefits coverage in 1955 and has been providing coverage to State of Washington employees through the Uniform Dental Plan since 1988. WDS is now the largest dental benefits provider in Washington State, serving more than one million people.

In 1994, the Uniform Dental Plan introduced the Washington Dental Service Participating Provider Organization (PPO) dental program. This program continues to provide enrollees with the freedom to choose any dentist, and it gives subscribers the opportunity to receive a higher level of coverage by receiving treatment from those dentists who participate in the WDS PPO. Today, more than 50 percent of the dentists in Washington participate in the WDS PPO program.

Washington Dental Service works closely with the dental profession to design dental plans that steer high-quality treatment along the most cost-effective path. As any dentist will tell you, the key to having good teeth and avoiding dental problems is prevention. The Uniform Dental Plan and all Washington Dental Service programs are structured to encourage regular dental visits and early treatment of dental problems while they are still minor.

Washington Dental Service is committed to providing the highest quality customer service to all enrollees. WDS's dedicated unit of customer service representatives are available toll-free to enrollees from 6 a.m. to 6 p.m. Monday through Thursday and 6:00 a.m. to 5:00 p.m. on Fridays. You can also access information through our Automated Inquiry System with a touch tone phone by entering your social security number.

We're happy to be serving 118,000 enrollees and thank you for enrolling in the Uniform Dental Plan.

INTRODUCTION

The Uniform Dental Plan (UDP) is administered under a plan of self-insurance by the state of Washington. Uniform Dental Plan services are provided through Washington Dental Service (WDS). Most licensed dentists in Washington State are WDS members. Member dentists agree to follow Uniform's requirements, such as filing their charges, completing and submitting claim forms and accepting direct payment from the plan.

To obtain services, inform your dentist that you are covered by the Uniform Dental Plan, WDS Program Number 3000.

RETIREE PARTICIPATION

You must be enrolled in a medical plan to enroll in the dental plan. If you enroll in the medical and dental plans, you must enroll the same eligible dependents under both plans. Once enrolled in the medical and dental package, you cannot change to "medical-only" for at least two years.

SERVICE AREA

The Uniform Dental Plan Participating Provider Organization (PPO) service area is all of Washington State. If you need assistance in locating a PPO provider in your area, please contact the plan.

The out-of-PPO service area is any location outside of Washington State. If you are treated by an out-of-state dentist, obtain a claim form from the Uniform Dental Plan and have the dentist complete it, then pay the dentist's bill and submit the claim to the Uniform Dental Plan. For covered services, the plan will pay either the dentist's charge or the amount normally paid WDS member dentists for the same services, whichever is less.

UNIFORM DENTAL PLAN PROVIDERS

WDS has member dentist contracts with some 2,800 dentists in the state of Washington. Under the Uniform Dental Plan, you have the option of seeking care from any licensed dentist whether or not the dentist is a member of WDS. However, your coverage is different if you see a PPO dentist within the member dentist system.

Member dentists have contracted with WDS to provide services to enrollees. Member dentists submit claim forms to the Uniform Dental Plan and receive payment based on their filed fees. You are responsible for the coinsurance up to the providers allowable fee.

A PPO dentist must be a WDS member dentist in order to participate in the Uniform Dental Plan Participating Provider Organization (PPO). PPO dentists receive payment based on their PPO filed fees at the percentage levels listed for PPO dentists. You are responsible for the coinsurance up to the PPO providers allowable fee.

A Non PPO member dentist is a member of WDS who is not part of the Uniform Dental Plan Participating Provider Organization (PPO). Non PPO member dentists receive payment based on their maximum allowable fees at the percentage levels listed for Non PPO dentists.

More than 50% of WDS member dentists participate in the Uniform Dental Plan/WDS PPO network. You are not required to choose a dentist at enrollment and are free to choose a different dentist each time you seek treatment. You will, however, receive a higher level of benefits when you obtain treatment from a PPO dentist, and there are no claims to file.

If you need assistance locating a PPO dentist in your area, or have questions about benefits or payment of claims, please call the Uniform Dental Plan. Customer service representatives are available weekdays from 6 a.m. to 6 p.m. Monday through Thursday and 6:00 a.m. to 5:00 p.m. on Fridays.

Nonmember dentists have not contracted with WDS. Payment for services performed by a nonmember dentist is based upon your dentist's actual charges or the maximum allowable fee, whichever is less, at the percentage levels listed for Non PPO dentists. If you use a nonmember dentist, obtain a claim form from the Uniform Dental Plan and have your dentist complete it. Then pay the dentist's bill and submit your claim to the Uniform Dental Plan. Reimbursement checks are made out jointly to you and your dentist.

DEDUCTIBLE

This plan has a $50 deductible per person ($150 deductible per family) per calendar year. Diagnostic/preventive services are not subject to the deductible.

MAXIMUM ANNUAL PLAN PAYMENT

The maximum amount of benefits payable for each enrollee in any one calendar year is $1,500.

LIFETIME BENEFIT MAXIMUMS

The lifetime maximum amounts payable per eligible person for covered dental benefits are:

1. Orthodontia: $750
2. Temporomandibular joint (TMJ) treatment: $500
3. Orthognathic surgery: $5,000

BENEFIT LEVELS FOR UNIFORM DENTAL PLAN

SERVICES	PPO Dentists in Washington State	Out of State	Non-PPO Dentist in Washington State
Diagnostic/preventive	100%	90%	80%
Restorative fillings	80%	80%	70%
Oral surgery	80%	80%	70%
Periodontic services	80%	80%	70%
Endodontic services	80%	80%	70%
Restorative crowns	50%	50%	40%
Prosthodontic (dentures and bridges)	50%	50%	40%
Orthodontic (to lifetime maximum plan payment of $750)	50%	50%	50%
Nonsurgical TMJ (to lifetime maximum plan payment of $500)	70%	70%	70%
Orthognathic (to lifetime maximum plan payment of $5,000)	70%	70%	70%

SPECIALTY TREATMENT

Specialty treatment is a covered benefit under the Uniform Dental Plan. As with all dental treatment, you will receive a higher level of benefits if you obtain treatment from a PPO dentist. You may want to ask your dentist to refer you to a PPO specialist in the event you need specialty care. PPO specialists are listed in the PPO directory, or you may contact the Uniform Dental Plan.

EMERGENCY CARE

Emergency care is defined as treatment for relief of pain resulting from an unexpected condition that requires immediate dental treatment. You should first contact your dentist. If your PPO dentist is not available, you should call the plan. WDS will find a PPO dentist who can treat you or will approve treatment from a non-PPO dentist and will pay benefits at the PPO benefit level. If an emergency occurs after regular office hours, you should first contact your PPO dentist. If your dentist is not available, you may seek treatment from any dentist for pain relief. If a PPO dentist is not available, your claim from a non-PPO dentist will be paid at the PPO benefit level.

Claims for emergency treatment received by a non-PPO dentist when your regular PPO dentist is not available must be sent with a written explanation to: Uniform Dental Plan, P.O. Box 75688, Seattle, WA 98125.

Emergencies outside the PPO service area are paid as any other treatment received outside the service area.

PREAUTHORIZATION

Preauthorization is required for all orthodontia, orthognathic surgery and temporomandibular joint treatment (TMJ) procedures or benefits will be reduced or denied. Emergency treatment does not require preauthorization. Emergency treatment is defined as that treatment necessary to control the sudden and acute onset of pain.

Preauthorization for Nonmember Dentists: If you receive treatment in Washington State and your dentist is not a member of WDS, the following procedures must be preauthorized: oral surgery (except simple extraction), periodontics, endodontics (root canals), crowns, bridges and prosthetics, and orthodontia, temporomandibular joint treatment (TMJ) and orthognathic surgery.

Preauthorization for Member and Out-of-State Dentists: If your dentist is a WDS member or is located outside Washington State, these procedures must be preauthorized: orthodontia, orthognathic surgery and temporomandibular joint treatment (TMJ).

SECOND OPINION

To determine covered benefits for certain treatments, the Uniform Dental Plan may require a patient to obtain a second opinion from a WDS-appointed consultant. The Uniform Dental Plan will pay 100% of the charges incurred for the second opinion.

PREDETERMINATION OF BENEFITS

If your dental care will be extensive, you may wish to know in advance exactly what procedures are covered, the amount the Uniform Dental Plan will pay toward the treatment, and your financial responsibility. A predetermination is strongly recommended for major procedures, such as periodontal surgery, crowns, inlays, onlays, occlusal guards, complete occlusal equilibration and prosthetics. To obtain a predetermination, ask your dentist to complete and submit a standard Uniform Dental Plan claim form. A predetermination is not a guarantee of benefits available. The actual benefits available are determined at the time of claims submission and are based on the specific service rendered and eligibility status at the time of service.

Alternative Procedures: In cases where there are alternative procedures of treatment with different fees, the plan will usually pay the appropriate percentage of the lower fee. However, the plan will pay the appropriate percentage of the higher fee if satisfactory evidence is submitted to the Uniform Dental Plan that the more expensive procedure is the only professionally adequate course of treatment.

COVERED DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS

The following covered dental benefits are subject to the limitations and exclusions contained in this booklet. Such benefits ***(as defined)*** are available only when rendered by a licensed dentist or other WDS-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and WDS. The amounts payable for covered dental benefits are as stated above. Claims for services must be submitted within 12 months of the completion of treatment.

CLASS I BENEFITS

DIAGNOSTIC SERVICES

Covered Dental Benefits: Routine examination, x-rays, emergency examination and examination by a specialist in an American Dental Association recognized specialty. WDS approved caries susceptibility tests.

Limitations: Examination is covered twice in a calendar year. Complete series (four bitewing x-rays and up to ten periapical x-rays) or panoramic x-rays are covered once every five years. Supplementary bitewing x-rays are covered once every 12 months.

Exclusions: Consultations or elective second opinions. Study models and charges for the review of a proposed treatment plan. Refer also to the General Exclusions section.

PREVENTIVE SERVICES

Covered Dental Benefits: Prophylaxis (cleaning), periodontal maintenance (cleaning), fissure sealants and topical application of fluoride; space maintainers when used to maintain space for eruption of permanent teeth.

Limitations: Any type of prophylaxis (cleaning) or periodontal maintenance (cleaning)***** is covered twice in a calendar year (refer to Class II, Periodontics, Limitations, for additional limitation information). Application of fluoride is covered twice in a calendar year through age eighteen (18). *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.* Fissure sealant application is payable for children once every three years per applicable tooth, through age fourteen (14). Payment for sealants will be made only for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. If eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption. Documentation must be provided by the attending dentist.

Exclusions: Plaque control program, oral hygiene instruction, dietary instruction and home fluoride kits, cleaning of a prosthetic appliance, and replacement of a space maintainer previously paid for by the plan. Refer also to the General Exclusions section.

***** Under certain conditions of oral health, periodontal maintenance and/or prophylaxis *may be* covered up to a total of four (4) times in a calendar year. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

CLASS II BENEFITS

RESTORATIVE SERVICES

Covered Dental Benefits: Amalgam, composite or filled resin restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp). Stainless steel crowns.

Limitations: Restorations on the same surface(s) of the same tooth are covered once in a two (2) year period. If a composite or filled resin restoration is placed in a posterior tooth, an amalgam allowance will be made for such procedure. The difference in cost is the patient's responsibility. Stainless steel crowns are covered once in a two (2) year period. Refer to Class III Limitations if teeth are restored with crowns, inlays or onlays.

Exclusions: Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion; overhang removal, recontouring or polishing of restoration. Refer also to the General Exclusions section.

ORAL SURGERY

Covered Dental Benefits: Major and minor oral surgeries that include the following general categories: removal of teeth, preprosthetic surgery, treatment of pathological conditions, traumatic facial injuries, ridge extension for insertion of denture (vestibuloplasty), and general anesthesia/intravenous sedation.

Limitations: General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other WDS approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with certain covered oral surgery procedures as determined by WDS.

Exclusions: Iliac crest or rib grafts to alveolar ridges. Tooth transplants. Refer also to the General Exclusions section.

PERIODONTIC SERVICES

Covered Dental Benefits: Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth including examinations, periodontal scaling/root planing, periodontal surgery, and general anesthesia/intravenous sedation. WDS approved locally applied antibiotics. Refer to Class III Periodontics for benefits and limitations on complete occlusal equilibration and occlusal guards (nightguards).

Limitations: Examinations are covered twice in a calendar year.. Periodontal scaling/root planing per site is covered once in a three (3) year period. Locally applied antibiotics approved by WDS are a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.* Osseous surgery (per site), gingival flap surgery (per site), soft tissue grafts (per site) are covered once in a three (3) year period. Osseous surgery and site specific therapy must be preceded by scaling and root planing a minimum of six (6) weeks and a maximum of six (6) months, or the patient must have been in active supportive periodontal therapy, prior to such treatment. General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other WDS approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with certain covered periodontal surgery procedures as determined by WDS.

Exclusions: Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances. Locally applied antibiotics are not covered when used for the purpose of maintaining non-covered dental procedures or implants. Refer also to the General Exclusions section.

ENDODONTICS

Covered Dental Benefits: Procedures for pulpal and root canal treatment, including pulp exposure treatment, pulpotomy and apicoectomy.

Limitations: Root canal treatment on the same tooth is covered only once in a two (2) year period. General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other WDS approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with certain covered endodontic surgery procedures as determined by WDS. Refer to Class III Limitations if the root canals are placed in conjunction with a prosthetic appliance.

Exclusions: Bleaching of teeth. Refer also to the General Exclusions section.

CLASS III BENEFITS

PERIODONTIC SERVICES

Covered Dental Benefits: Under certain conditions of oral health, services covered are: occlusal guards (nightguards) and complete occlusal equilibration. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

Limitations: Occlusal guards, including repairs, are covered once in a three (3) year period. Occlusal equilibration is covered, under current WDS processing policies, once in a lifetime.

Exclusions: Periodontal splinting, crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances.

RESTORATIVE SERVICES

Covered Dental Benefits: Crowns, inlays (only when used as an retainers for fixed bridges), onlays (whether they are gold, porcelain, WDS-approved gold substitute castings [except processed resin] or combinations thereof), limited occlusal adjustment, build-ups for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or filled resins.

Limitations: Crowns or onlays on the same teeth are covered once in a five (5) year period. Inlays are a covered benefit on the same teeth once in a five (5) year period only when used as a retainer for a fixed bridge. Build-ups are covered once in a two (2) year period. If a tooth can be restored with a filling material such as amalgam or filled resin, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided. WDS will allow the appropriate amount for an amalgam or composite restoration toward the cost of another material of higher cost.

Exclusions: A crown used as an abutment to a partial denture for purposes of recontouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required. Crowns used to repair micro-fractures of tooth structure when the teeth are asymptomatic (displays no symptoms) or existing restorations with defective margins when no pathology exists. Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology. Refer also to the General Exclusions section.

POSTHODONTIC SERVICES

Covered Dental Benefits: Dentures, fixed bridges, removable partial dentures and the adjustment or repair of an existing prosthetic device. Surgical placement or removal of implants or attachments to implants.

Limitations: Replacement of an existing prosthetic device is covered only once every five years and only then if it is unserviceable and cannot be made serviceable. Replacement of implants and superstructures is covered only after five years have elapsed from any prior provision of the implant.

1. **Full, immediate and overdentures**. The plan will allow the appropriate amount for a complete, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment. Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III Payment Level.

2. **Temporary/interim dentures**. The plan will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after twelve (12) months.
3. **Partial dentures**. If a more elaborate or precision device is used to restore the case, the plan will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
4. **Denture adjustments and relines**. Denture adjustments and relines done more than six months after the initial placement are covered, except as noted under Temporary/interim dentures. Subsequent relines or jump rebases (but not both) will be covered once in a twelve (12) month period.

Exclusions: Duplicate dentures, personalized dentures, cleaning of prosthetic appliances, crowns and copings in conjunction with overdentures. Refer also to the General Exclusions section.

ORTHODONTIA BENEFITS

All orthodontic treatment must be submitted to and authorized by the Uniform Dental Plan before treatment begins. Failure to have treatment preauthorized could result in a reduction or denial of benefits under this plan.

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

The lifetime maximum amount payable for orthodontic benefits rendered to an eligible person is $750. Not more than $375 of the maximum, or one-half of the plan's total responsibility, shall be payable for treatment during the "construction phase." The final payment shall be made during the seventh month following the construction phase, providing the employee is eligible and the dependent is in compliance with the age limitation. The plan will not pay for treatment if claim forms are submitted more than 12 months after banding date.

The amount payable for orthodontic treatment shall be 50% of the lesser of the maximum allowable fees or the fees actually charged.

Covered Dental Benefits: Treatment of malalignment of teeth and/or jaws that significantly interferes with the act of mastication (chewing). Orthodontic work that began prior to the eligible person's effective date but was completed after the effective date will be considered for payment on a prorated basis.

In addition to the limitations and exclusions contained in this booklet, the following also apply to orthodontic treatment:

Limitations: Payment of monthly or other periodic charges is limited to:

1. Completion, or through age 22 for eligible dependent children, if full-time students, whichever occurs first.
2. Termination of the treatment plan prior to completion of the case.
3. Termination of this plan. If coverage ends (because of age or termination of the plan) while treatment is still in progress, only services completed up to the date coverage ends will be covered.

Exclusions:

1. Charges for replacement or repair of an appliance.
2. No benefits will be provided for services considered inappropriate and unnecessary, as determined by the Uniform Dental Plan.
3. Refer also to the General Exclusions section.

TEMPOROMANDIBULAR JOINT TREATMENT

All temporomandibular joint (TMJ) benefits must be preauthorized by the Uniform Dental Plan before treatment begins. Benefits will be denied if treatment is not preauthorized.

TMJ treatment is defined as nonsurgical intra-oral services provided by a licensed dentist or physician, when necessary and customary according to the standards of generally accepted dental practice, for the treatment of dental symptoms associated with the malfunction of the temporomandibular joint, including myofacial pain dysfunction. These procedures include:

- TMJ examination
- X-rays (TMJ film and arthrogram)
- Temporary repositioning splint
- Occlusal guard (nightguard)
- Removable metal overlay stabilizing appliance
- Stabilizing appliance
- Full mouth occlusal equilibration
- Arthrocentesis
- Manipulation under local anesthesia

The amount payable for TMJ benefits shall be 70% of the lesser of the maximum allowable fees or the fees actually charged. The lifetime maximum amount payable for TMJ benefits rendered to an eligible person is $500.

To obtain authorization, dentists must submit documentation for necessity of treatment to the Uniform Dental Plan with a proposed treatment plan.

In addition to the limitations and exclusions set forth in this booklet, the following also apply to TMJ benefits:

1. The plan shall not pay for the repair or replacement of any appliance furnished in whole or in part for temporomandibular joints.
2. The plan shall not cover services that would normally be provided under medical care, including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
3. Fixed appliances and restorations are not covered.
4. With the exception of TMJ examinations, TMJ film and arthrogram, diagnostic procedures not otherwise covered under the plan are not covered herein.
5. Any procedures that are performed in conjunction with TMJ services, and are covered benefits under another portion of the dental plan, are not covered under this portion.

ORTHOGNATHIC SURGERY

All orthognathic treatment must be submitted to and authorized by the Uniform Dental Plan before treatment begins. Benefits will be denied if treatment is not preauthorized.

Orthognathic treatment is defined as the necessary surgical procedures of treatment, performed by a licensed dentist or physician, to correct the malposition of the maxilla (upper jaw bone) and/or the mandible (lower jaw bone).

The amount payable for orthognathic treatment shall be 70% of the lesser of the maximum allowable fees or the fees actually charged. The lifetime maximum amount payable for orthognathic benefits rendered to an eligible person is $5,000.

In addition to the limitations and exclusions set forth in this booklet, the following also apply to orthognathic treatment:

Limitations: Complications will be covered only if treatment is sought within 30 days from the original treatment.

Exclusions: The plan shall not cover:

1. Services that would be provided under medical care including, but not limited to, hospital and professional services.
2. Diagnostic procedures not otherwise covered under this plan.
3. Any procedures that are performed in conjunction with orthognathic surgery services, and are covered benefits under another portion of the dental plan.
4. Refer also to the General Exclusions section.

GENERAL EXCLUSIONS

In addition to the specific exclusions and limitations stated elsewhere in this booklet, the UDP does not provide benefits for:

1. Dentistry for cosmetic reasons. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching.
2. Restorations or appliances necessary to increase or alter the vertical dimension or to restore the occlusion. Excluded procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth.
3. Application of desensitizing medicaments.
4. Services or supplies that the Uniform Dental Plan determines are experimental or investigative. Determination is made according to the following criteria. If any of these situations are met, the service or supply is considered experimental and/or investigative, and benefits will not be provided.
   a. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.
   b. The provider has not demonstrated proficiency in the service, based on experience, outcome or volume of cases.
   c. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.
   d. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to the enrollee's health or safety.

   Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider's written protocols or scientific data from another provider studying the same service.

   The documentation used to establish the plan's criteria will be made available for your examination at the office of the Uniform Dental Plan, if you send a written request.

   If the Uniform Dental Plan determines that a service is experimental or investigative, and therefore not covered, you may appeal the decision. The Uniform Dental Plan will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.
5. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as premedication and nitrous oxide.
6. General anesthesia, including intravenous and inhalation sedation, with two exceptions: a) when in conjunction with covered oral surgery, endodontic and periodontal surgical procedures; and b) coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of seven, or physically or developmentally disabled.

7. Hospital or other facilities care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
   a. A hospital setting for the dental care must be medically necessary.
   b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
   c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by the Uniform Dental Plan. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

   If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.
8. Dental services started prior to the date the person became eligible for services under this plan, except as provided for orthodontic benefits.
9. Services for accidental injury to natural teeth when evaluation of treatment and development of treatment plan is performed more than 30 days from the date of the injury.
10. Expenses incurred after termination of coverage, except expenses for:
    a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
    b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
    c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
11. Missed appointments.
12. Completing insurance forms or reports, or for providing records.
13. Habit-breaking appliances, except as specified under the orthodontia benefit.
14. Full-mouth reconstruction.
15. Charges for dental services performed by anyone who is not a licensed dentist or physician, as specified.
16. Services or supplies that are not listed as covered.
17. Treatment of congenital deformity or malformations.
18. Orthodontic treatment, orthognathic treatment, and treatment of TMJ disorders that are not authorized in advance by the Uniform Dental Plan.
19. Replacement of lost or broken dentures or other appliances.
20. Services for which an enrollee has contractual right to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowners or other no-fault insurance.
21. In the event an Eligible Person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
22. WDS shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the Contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract.

ELIGIBILITY

(See "When Coverage Begins" To Determine When Coverage For Eligible Enrollees Begins)

ELIGIBLE EMPLOYEES

Employees (referred to in this book as "employees," "subscribers" or, in some cases, "enrollees") of state government, higher education, K-12 school districts, educational service districts, participating employer groups (such as cities, counties, ports, water districts, etc.) and employee organizations representing state civil service workers are eligible to apply for coverage by PEBB plans in accordance with WAC 182-12-115. An employee is eligible for coverage by only one PEBB-sponsored dental plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person.

Eligibility for employees of participating "employer groups" may follow PEBB rules or rules determined by collective bargaining agreement, if approved by the HCA in accordance with WAC 182-12-115.

ELIGIBLE RETIREES

Retired or permanently disabled employees, (referred to in this book as "retirees," "subscribers" or, in some cases, "enrollees") of state government, higher education, K-12 school districts, educational service districts and participating employer groups are eligible for coverage by PEBB plans on a self-pay basis in accordance with WAC 182-12-117 contingent upon enrollment in a PEBB medical plan. A retired or permanently disabled employee under WAC 182-12-117, is eligible for coverage by only one PEBB-sponsored dental plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person. In order to be eligible, the following conditions must be met:

1. a.) Under the following state of Washington retirement systems individuals must immediately begin receiving a monthly retirement allowance, or have taken a lump-sum payment because their monthly benefit would be less than $50:

    i. Public Employees Retirement System, PERS 1,2, or 3 (with the exception noted below in section 1.b.i.);
    ii. Teachers' Retirement System, TRS 1, 2 or 3 (with the exception noted below in section 1.b.i.);
    iii Higher Education Retirement Plan (e.g. TIAA-CREF) (with the exception noted below in section 1.b.ii.);
    iv. Law Enforcement Officers' and Fire Fighters' Retirement System, LEOFF 1 or 2;
    v. State Judges/Judicial Retirement System;
    vi. Washington State Patrol Retirement System; or
    vii. School Employees Retirement System (SERS 2 or 3), (with the exception noted below in section 1.b.i.).

    b.) Individuals in the following state of Washington retirement systems are not required to begin receiving a monthly retirement allowance, but may instead meet these conditions:

    i. Public Employees Retirement System, PERS 3, Teachers' Retirement System, TRS 3, and School Employees Retirement System, SERS 3, not receiving a monthly retirement allowance (defined benefit) must be at least age 55 with at least 10 years of service credit at the time of separation;
    ii. Higher Education Retirement Plan (e.g., TIAA-CREF), must meet equivalent years of service and age requirements of the PERS retirement system to have qualified for a retirement benefit had the person been employed under the provisions of PERS 1 or PERS 2 for the same period of employment.

c.) Employees who are permanently disabled are eligible if they receive a deferred monthly retirement income benefit and they apply for retiree coverage before their active employment ends.

2. All retirees must submit an application for retiree medical coverage no later than 60 days after their active employment ends or their continuous COBRA coverage ends. Retirees may enroll in a PEBB dental plan at that time or during any PEBB open enrollment period as long as the enrollee has PEBB medical plan coverage.

Appointed and elected officials, of the legislative and executive branches of state government, who leave public office may continue their PEBB dental coverage on a self-pay basis, contingent upon enrollment in a PEBB medical plan, whether or not they receive a retirement benefit from a state retirement system, provided they apply no later than 60 days after the end of their term.

ELIGIBLE DEPENDENTS

Eligible subscribers may enroll dependents in their PEBB-sponsored dental plan. Retiree dependent dental enrollment is contingent upon enrollment in a PEBB medical plan. A dependent is eligible for coverage by only one PEBB-sponsored dental plan even if eligibility criteria are met under two or more plans. For example, a dependent child that is eligible for coverage under two or more parents or stepparents who are employed by PEBB-participating employers, may be enrolled as a dependent under the coverage of one parent or stepparent, but not more than one. The following dependents are eligible:

1. The subscriber's lawful spouse or same-sex domestic partner (qualified through the declaration certificate).

2. Dependent children through age 19. The term "children" includes the subscriber's natural children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the subscriber's qualified same-sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as dependents of the subscriber under the Internal Revenue Code, and additional legal dependents approved by the HCA are included. Dependent children beyond the age of 19 are eligible under the following conditions:

   a. Students age 20 through age 23 are eligible if they are: (i) dependent on the subscriber for maintenance and support, and (ii) are registered and attend full-time an accredited secondary school, college, university, vocational school or school of nursing. In order to certify and recertify eligibility the subscriber must submit a Student Certification Form to HCA for review. Along with the certification, the subscriber must provide proof that the dependent (ages 20 through 23) is a full-time student. Acceptable proof may include: 1) current quarter/semester registration from institution; or 2) past year report card/transcript from institution showing credit hours completed. If documentation identifies a non-eligible period for the dependent, coverage will be terminated for that time period the student was not eligible. Payment for any services provided to the ineligible student will be the responsibility of the subscriber. Dependent student coverage continues year-round for those who attend three of the four school quarters, and for three full calendar months following graduation as long as the subscriber is covered at the same time.

   b. Dependent children of any age are eligible if they are incapable of self-support due to developmental disability or physical handicap, provided that their condition occurred before age 20, or during the time they were covered under a PEBB plan as a full-time student. In order for coverage to continue beyond the limiting age or loss of student eligibility, an application and proof of disability must be submitted to the HCA. The HCA will request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.

3. Dependent parents covered under a PEBB dental plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous coverage in a PEBB-sponsored dental plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible subscriber, (c) the subscriber who claimed the parent as a dependent continues enrollment in a PEBB program, and (d) the parent is not covered by any other group dental insurance. Dependent parents must maintain coverage under a PEBB medical plan to continue enrollment in a PEBB dental plan, and may not continue PEBB dental coverage if they are covered by other group dental coverage. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible subscriber; however, dependent parents may not add additional family members to their coverage.

4. Dependents of an active employee who were previously covered under a K-12 health plan, and who are not otherwise eligible for PEBB coverage, may continue coverage under a PEBB plan for up to 36 consecutive months. In order to be eligible for this continuation, the PEBB plan must be immediately replacing a K-12 health plan with no lapse in coverage.

5. If a dependent loses eligibility under a PEBB plan for active employees due to the death of the employee, the dependent(s) may continue coverage under a retiree plan provided the dependent(s) will immediately begin receiving a monthly benefit from any state of Washington-sponsored retirement system. The employee's spouse or qualified domestic partner may continue coverage indefinitely; other dependents may continue coverage until they lose eligibility under PEBB rules. Application for surviving dependent coverage must be made within 60 days from the death of the employee. If a dependent does not receive a retirement benefit as described, see the "Options For Continuing Benefits" Section.

Verification of the dependency status of anyone enrolled under the PEBB coverage may be requested at any time by the HCA or Washington Dental Service.

ENROLLMENT

(See "When Coverage Begins" To Determine
When Coverage For Eligible Enrollees Begins)

ELIGIBLE EMPLOYEES AND DEPENDENTS

Employees and their eligible dependents must enroll in a PEBB dental plan within 31 days of the date the employee first becomes eligible to apply for PEBB coverage as described in the section titled "Eligibility." Enrollment forms are furnished by the employee's payroll, personnel or insurance office and should be returned to that office within 31 days of the date of eligibility. Failure to enroll in dental coverage within 31 days will result in automatic enrollment in the Uniform Dental Plan.

An employee/dependent is eligible to enroll in only one PEBB-sponsored dental plan even if eligibility criteria are met under two or more plans.

ELIGIBLE RETIREES AND DEPENDENTS

If a retiree chooses to enroll in a dental plan at either the date of retirement or during an open enrollment period, the retiree must maintain dental coverage for a period of not less than two years. If a retiree subsequently disenrolls from both their medical and dental plans, they are not eligible to reenroll in a PEBB plan at a later date except as specifically noted in this benefit book. Information on the premiums and coverage’s available will be included in the retiree packet provided to the retiree upon application to the HCA.

A retiree/dependent is eligible to enroll in only one PEBB-sponsored dental plan even if eligibility criteria are met under two or more plans.

WAIVER OF COVERAGE

Employees eligible for PEBB dental coverage have the option of waiving dental coverage for any or all dependents if they are covered by another dental plan. In order to waive coverage, the employee must complete an enrollment form that identifies the individuals for whom coverage is being waived.

If PEBB dental coverage is waived, an otherwise eligible person may not enroll in a PEBB plan until the next open enrollment period, or within 31 days of loss of other dental coverage. Proof of other dental coverage is required to demonstrate that: 1) coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 31 days or less.

The employee may have an additional opportunity to enroll dependents in the event of acquisition of a new dependent as a result of marriage, same-sex domestic partnership, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage or establishment of a qualified same-sex domestic partnership, or within 60 days of birth, adoption or placement for adoption.

RETIREE WAIVER OF COVERAGE

Retirees who cancel their PEBB retiree coverage, will **not** be allowed to enroll again later, except as outlined below.

Retirees may waive PEBB medical and dental coverage for themselves and all dependents if they are covered under another comprehensive employer-provided benefits package. (Other coverage may be attained through the retiree's re-employment or the spouse's/same-sex domestic partner's employment.) Dental coverage is automatically waived if the retiree waived medical coverage. Other group retiree coverage does not qualify as "employer-provided coverage." Employees must qualify as a PEBB retiree when they leave employment with Washington State, as outlined in WAC 182-12-117.

Retirees and their eligible dependents who waived PEBB medical coverage while enrolled in other comprehensive employer-provided coverage, may enroll in the PEBB coverage within 60 days of the date other employer-provided coverage ends. Proof of continuous enrollment in comprehensive employer-provided coverage is required with application.

The retiree may have an additional opportunity to enroll dependents in the event of acquisition of a new dependent as a result of marriage, same-sex domestic partnership, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage or establishment of a qualified same-sex domestic partnership, or within 60 days of birth, adoption or placement for adoption.

ENROLLING A DEPENDENT ACQUIRED AFTER THE EMPLOYEE'S OR RETIREE'S (SUBSCRIBER'S) EFFECTIVE DATE OF COVERAGE

Subscribers may enroll dependents who become eligible after the subscriber's effective date by observing the following guidelines:

New dependents added due to the subscriber's marriage or addition of a qualified same-sex domestic partner should enroll within 31 days of eligibility to avoid delay in claims payment or denial of claims. Contact your personnel, payroll or insurance office for an enrollment form.

Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the subscriber should notify their personnel, payroll, insurance office of the birth, or the placement of the adoptive child, as soon as possible in order to ensure timely payment of claims. Retirees should contact the HCA.

When a newborn or adoptive child becomes eligible before the 16th day of the month, and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

Dependents who lose other dental coverage must be enrolled within 31 days of the date their other coverage ends. Dependents will be required to provide proof of continuous dental coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.

Eligible dependents may be added during any open enrollment period determined by the HCA without proof of continuous coverage.

Retirees should contact the HCA or the benefits office of the retiree's higher education institution for an enrollment form. Other subscribers should contact their personnel, payroll or insurance office, or the HCA for an enrollment form.

DISENROLLING A DEPENDENT

A dependent may be deleted from coverage by submitting an enrollment/change form. Retirees should contact the HCA or the benefits office of the retiree's higher education institution for forms and information on how to update their records. Other subscribers should contact their payroll, personnel or insurance office. Failure to delete a dependent in a timely manner may result in loss of continuation privileges for the dependent and retroactive denial of claims. Please refer to the section titled "Options for Continuing Benefits" for more information.

Enrollment changes should be made as soon as possible.

WHEN COVERAGE BEGINS

Coverage will begin for employees, retirees and their dependents as follows:

FOR EMPLOYEES:

1. **PERMANENT EMPLOYEES, SEASONAL EMPLOYEES, CAREER SEASONAL/ INSTRUCTIONAL EMPLOYEES:** Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment.
2. **NONPERMANENT EMPLOYEES:** Coverage for nonpermanent employees begins on the first day of the seventh calendar month following the date of employment.
3. **PART-TIME FACULTY:** Coverage for part-time faculty begins on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, coverage begins at the beginning of the second consecutive quarter/semester.
4. **APPOINTED AND ELECTED OFFICIALS, JUDGES:** Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of a month, coverage begins on the first day of their term.

   Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of state government, and judges, on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term

begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins, or the oath of office is taken.

5. **EMPLOYEES OF SCHOOL DISTRICTS AND PARTICIPATING EMPLOYER GROUPS:** The effective date of coverage for eligible employees may be determined by the terms of employment or collective bargaining agreement. Participation of the bargaining unit or non-represented employees is subject to approval by the HCA.

FOR RETIREES:

Coverage for eligible retirees begins on the day following loss of coverage as an active employee provided application for retiree coverage is made in accordance with PEBB rules.

FOR DEPENDENTS:

Coverage for eligible dependents begins on the day the subscriber's coverage begins if the subscriber lists the dependents on the application for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins on the first day of the month following the date of acquisition/declaration. If the date of acquisition/declaration is the first day of a month, coverage will begin on the first day of the month of acquisition/declaration.

Coverage for a newborn child begins at birth. Coverage for an adoptive child begins on the date that the subscriber assumes a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the first of the month following the date the condition of dependency is established and approved by the HCA. If the condition of dependency is established and approved as the first day of a month, coverage will begin on the date dependency is established.

SPECIAL ENROLLMENT FOR DEPENDENTS OF EMPLOYEES WHO PREVIOUSLY WAIVED COVERAGE

Coverage for eligible dependents whose dental coverage was previously waived will be effective as described below.

1. Coverage for eligible dependents enrolling because of loss of other dental coverage will begin on the first day of the month following the date the prior coverage terminated. The application must be received by the employee's payroll, personnel or insurance office within 31 days of termination of other dental coverage, and proof of other continuous coverage must be provided.
2. Coverage for eligible dependents enrolling following a marriage or establishment of a qualified same-sex domestic partner relationship, will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by the employee's payroll, personnel or insurance office within 31 days of the date of marriage/date that the same-sex domestic partnership qualifies based on the declaration.
3. Coverage for eligible dependents enrolling following a birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the employee assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by the employee's payroll, personnel or insurance office within 60 days of the birth or date of placement.

RETIREE SPECIAL ENROLLMENT FOR DEPENDENTS WHO PREVIOUSLY WAIVED COVERAGE

Coverage for eligible dependents of retirees whose dental coverage was previously waived will be effective as described below.

1. Eligible dependents that were waived **while the retiree maintained enrollment in a PEBB** dental plan may be enrolled during any open enrollment period designated by the HCA, or within 60 days of loss of other dental coverage. Proof of other dental coverage is required to demonstrate that: 1) coverage was continuous; and 2) the period between loss of coverage and application for PEBB coverage is 60 days or less. Coverage for eligible dependents enrolling because of loss of other dental coverage will begin on the first day of the month following the date prior coverage terminated. The application must be received by HCA within 60 days of termination of other dental coverage.
2. Retiree's marriage or qualified same-sex domestic partner relationship: Coverage for eligible dependents enrolling following a marriage or establishment of a qualified same-sex domestic partner relationship, will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by the HCA within 31 days of the date of marriage/date that the same-sex domestic partnership qualifies based on the declaration.
3. Birth or adoption: Coverage for eligible dependents enrolling following the birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the retiree assumes a legal obligation for total or partial support in anticipation of the adoption of the child. The application for coverage must be received by the HCA within 60 days of the birth or date of placement.

CHANGING DENTAL PLANS MID-YEAR

Enrollees may change dental plans in the following situations:

1. During an open enrollment period announced by the HCA.
2. If an enrollee changes residence during the plan year, they may change plan enrollment within 31 days of their move under the following conditions: if an enrollee moves from their plan's service area, they may enroll in any plan available in their new locality, or if a plan has not been available to the enrollee and they move into that plan's service area, they may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date enrollee moves.
3. If a court order requires a subscriber to provide dental coverage for an eligible spouse or child, the subscriber may change dental plans and add the dependent immediately, with the change effective retroactive to the effective date of the court order or the subscriber's effective date of coverage, whichever is later.
4. If a subscriber retires for any reason, the subscriber may change plans at the time of application for retiree coverage. The change will become effective on the first day of the month following the retirement date.
5. Seasonal employees whose off-season occurs during open enrollment may change plans within 31 days of returning to work.

To change plans, subscribers must fill out an enrollment/change form:

1. **Retirees** should contact the HCA or the benefits office of their higher education institution to update their records.
2. **Other Subscribers** should contact their payroll, personnel or insurance offices for forms and information on how to update their records.

NOTE: If an enrollee's dentist or other dental practitioner discontinues participation in an enrollee's plan, the enrollee may not change plans until the next open enrollment period. Also, if an enrollee transfers from one agency or school to another during the plan year, the enrollee is not permitted to change plans, except as outlined above.

WHEN COVERAGE ENDS

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
2. For an employee who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends for the employee and dependents (subject to the dependent's rights to continue coverage): (a) at 12 o'clock midnight on the last day of the month in which the employee is in pay status, or (b) at the end of the last month for which the employer has paid a premium contribution for reasons other than the employee's termination (such as leave without pay, reduction in force, retirement or an employee's application for disability retirement).
3. If the retiree stops paying monthly premiums, coverage ends for the retiree and dependents on the last day of the month for which the last full premium was paid.
4. For a dependent who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends at the end of the month in which he or she ceases to qualify as a dependent (such as a non-student child reaching age 20, or a spouse when a final decree of is entered).
5. For an enrollee who has chosen to continue coverage on a self-pay basis, such coverage ends: (a) on the date the enrollee is otherwise enrolled in other group dental coverage; or (b) at the end of the last month in which the enrollee is eligible to continue coverage or for which the premium has been paid.
6. For a terminated employee who has chosen to continue coverage on a self-pay basis, the employer paid premium will cover the employee through the end of the month in which the termination of employment occurs, and the self-pay premium will cover the employee beginning the first of the following month.
7. Premium payments are not prorated if an enrollee dies or terminates coverage prior to the end of the month.

OPTIONS FOR CONTINUING BENEFITS EMPLOYEES AND THEIR DEPENDENTS

Employees covered by a PEBB dental plan have options for providing continued coverage for themselves and their dependents during temporary or permanent loss of eligibility: (1) PEBB rules allow self-paid continuation of group coverage for up to 29 months, (2) the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives enrollees the right to continue group coverage for a period of 18 to 36 months, and (3) the Family and Medical Leave Act of 1993 gives the enrollee the opportunity to extend eligibility with employer contribution toward premium for up to 12 weeks. The dependents of employees also have options for continuing coverage for themselves following loss of eligibility.

Enrollees are not allowed to change dental plans at the time benefits are continued on a self-pay basis or when the enrollee returns to active status. Enrollees will be allowed to change PEBB plans only as described in the section titled "Changing Dental Plans Mid-Year."

When an employee returns to work:

1. Employees electing to self-pay dental coverage during an approved leave without pay will be eligible for employer-sponsored benefits the first of the month in which they return to work. Their self-pay premium will be refunded and the agency will remit the employer contribution to the HCA for that month.

2. When employees elect not to self-pay during an approved leave without pay, and they return to work in an eligible position, insurance benefits will begin on the first of the month following their return to work.

FAMILY AND MEDICAL LEAVE ACT OF 1993

Employer contributions toward PEBB plan coverage will continue up to the first 12 weeks of approved family leave in accordance with the Family and Medical Leave Act of 1993. After that, coverage may be continued as explained in the section titled "Continuing Coverage Under PEBB Rules."

PAYMENT OF PREMIUM DURING A LABOR DISPUTE

Any employee or dependent whose monthly fees hereunder are paid in full or in part by the employer, may pay the fees directly to the HCA, or Washington Dental Service if the employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six (6) months.

During the period the employee's compensation is suspended or terminated, the employee shall be notified immediately by the HCA, in writing, by mail addressed to the last address of record with the HCA, that the employee may pay the fees as they become due as provided in this Section.

CONTINUING COVERAGE UNDER PEBB RULES

When an employee loses eligibility as an active employee, PEBB group coverage may be continued at the group premium rate by self-paying premiums for a maximum of 29 months, except that part-time faculty may self-pay for group coverage between periods of active employee eligibility for a maximum of 18 months. If an employee is temporarily not in pay status for any of the following reasons, he or she may continue PEBB group coverage by self-paying the premium if:

1. the employee is on authorized leave without pay;
2. the employee is laid off because of a reduction in force (RIF);
3. the employee is receiving time-loss benefits under Workers' Compensation;
4. the employee is awaiting hearing for a dismissal action; or
5. the employee is applying for disability retirement.

This 29-month period shall be reduced by the number of months of self-pay allowed under the federal COBRA law and the federal Family and Medical Leave Act of 1993.

Employees who revert to a previously held position and do not regain pay status during the last month in which their employer contribution is made may continue their PEBB-sponsored health coverage, by self-paying premium for up to 18 months (and in some cases up to 29 months).

If a dependent(s) loses eligibility due to the death of the employee, the dependent(s) may continue coverage under a retiree plan provided the dependent(s) will immediately begin receiving a monthly benefit from any state of Washington-sponsored retirement system. The employee's spouse or qualified same-sex domestic partner may continue medical and dental coverage indefinitely; other dependents may continue medical and dental coverage until they lose eligibility under PEBB rules. Application for surviving dependent coverage must be made within 60 days from the death of the employee. If a dependent is not eligible for a monthly retirement income benefit or lump-sum payment because the monthly pension payment would be less than $50, the dependent may be eligible for continued coverage under COBRA.

Each of the employee's enrolled dependents is entitled to make a separate decision to exercise this continuation option.

CONTINUING COVERAGE UNDER THE FEDERAL COBRA LAW

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments, employers are required (in most situations) to offer continuation of group coverage to enrollees losing eligibility for such coverage. When a "qualifying event" ends eligibility for coverage, the enrollee or dependent must contact the enrollee's payroll, personnel, insurance office, or the HCA at (360) 412-4200 within 60 days of the qualifying event for information about the right to COBRA continuation and self-pay premium rates. Failure to notify the payroll, personnel, insurance office or the HCA may result in the loss of COBRA continuation privileges and retroactive denial of claims. If enrollees have the right to continue group coverage, they must submit an enrollment form within 60 days of the qualifying event. Enrollees are required to pay their own premiums, which begin accruing the first day of the month following the qualifying event. Qualifying events:

1. The employee and his or her covered dependents may continue PEBB-sponsored group coverage for up to 18 consecutive months if the qualifying event is: (a) reduction of the employee's work hours, or (b) termination of employment, except for discharge due to actions defined by the employer as gross misconduct. A second qualifying event during this 18-month period may extend the continuation period of dependents. Employees continuing their PEBB coverage under the Federal COBRA law after termination of employment or reduction in hours, and who are disabled under Title II of the Social Security Act at any time during the first 60 days of COBRA coverage, can extend the continuation period an additional 11 months for all covered individuals. To qualify for the extended coverage, the HCA must be notified before the end of the initial 18months of COBRA coverage and within 60 days of the disability determination.
2. The covered spouse or children may continue coverage for up to 36 consecutive months if the qualifying event is: (a) the employee's death, (b) divorce, or (c) a child's loss of eligibility for dependent coverage.

COBRA subscribers may add eligible dependents in accordance with PEBB rules after their continuation period begins. However, those added dependents are not eligible for further coverage if a second qualifying event should occur.

Continued coverage will end on the last day of the monthly period for which premiums have been paid in which the first of the following occurs:

1. the applicable continuation period expires;
2. the next required premium payment is not made when due;
3. the enrollee becomes covered under another group dental plan, unless the new plan covering the enrollee contains a preexisting condition exclusion or limitation that applies to the enrollee (in which case COBRA coverage will cease on the earlier of (a) the end of the COBRA continuation period, or (b) the cessation of the application of the preexisting condition exclusion); or
4. the former employer ceases to offer group dental coverage.

Each of the employee's enrolled dependents is entitled to make a separate decision to exercise their COBRA continuation option.

EXTENSION OF COVERAGE FOR COVERED DEPENDENTS NOT ELIGIBILE FOR COBRA

The following dependents are eligible for an 18-month extension of coverage if the employee loses coverage due to one of the following events: (a) reduction of the employee's work hours, or (b) termination of employment, except for discharge due to actions defined by the employer as gross misconduct. A second event during this 18-month period may extend the continuation period for dependents up to a total of 36 consecutive months if the event is: (a) the employee's death, (b) termination of a qualified domestic partnership, (c) election of Medicare as the employee's primary medical coverage, or (d) a child's loss of eligibility for dependent coverage.

- Covered dependents of an employer group subscriber who do not meet PEBB dependent eligibility as defined in WAC 182-12-119
- Qualified domestic partner.
- Children eligible through a qualified domestic partnership.

When an event ends eligibility for coverage, the enrollee must contact the employee's payroll, personnel, insurance office or the HCA at (360) 412-4200 within 60 days of the qualifying event for information about the right to an extension of coverage and self-pay premium rates. Enrollees are required to pay their own premium, which begins accruing the first day of the month following the qualifying event. If enrollees have the right to continue group coverage, they must enroll within 60 days of the qualifying event, and will be required to pay their own premiums. Failure to notify the payroll, personnel, insurance office or the HCA may result in the loss of continuation privileges and retroactive denial of claims.

OPTIONS FOR CONTINUING BENEFITS
RETIREES COVERAGE

Some enrollees covered by this plan who lose eligibility have options for continuing coverage, contingent upon enrollment in a PEBB medical plan. PEBB rules allow for continued retiree coverage of dependents of a deceased subscriber. The dependents of retirees also have options for continuing coverage for themselves following loss of eligibility.

CONTINUING RETIREE COVERAGE UNDER PEBB RULES

The surviving dependents of a deceased retiree who were enrolled in a PEBB retiree plan at the time of the retiree's death may continue their coverage on a self-pay basis. The retiree's spouse or qualified same-sex domestic partner may continue coverage indefinitely, contingent upon enrollment in a PEBB medical plan; other dependents may continue coverage until they lose eligibility under PEBB rules, contingent upon enrollment in a PEBB medical plan.

Enrollees should contact the HCA or the benefits office of the retiree's higher education institution for an enrollment form. Application for surviving dependent coverage must be made within 60 days from the death of the retiree.

CONTINUING RETIREE COVERAGE UNDER THE FEDERAL COBRA LAW

In certain cases, the federal COBRA law gives enrollees the right to continue coverage by self-paying the COBRA monthly group coverage premiums. When a "qualifying event" ends eligibility for coverage, the enrollee must contact the HCA or the benefits office of the retiree's higher education institution within 60 days of the qualifying event for information about the right to COBRA continuation and self-pay premium rates. If enrollees have the right to continue group coverage, they must submit an enrollment form within 60 days of the qualifying event. Failure to notify the HCA or the benefits office of the retiree's higher education institution may result in the loss of COBRA continuation privileges and retroactive denial of claims. Qualifying events:

1. The covered spouse or children may continue coverage for up to 36 consecutive months if the qualifying event is: (a) divorce, or (b) a child's loss of eligibility for dependent coverage.

2. Enrollees may continue coverage for up to 18 consecutive months when the subscriber no longer qualifies for disability retirement.

COBRA subscribers may add eligible family members in accordance with PEBB rules after their continuation period begins. However, those added dependents are not eligible for further coverage if a second qualifying event should occur.

Continued coverage will end on the last day of the monthly period for which premiums have been paid in which the first of the following occurs:

1. the applicable continuation period expires;
2. the required premium payment is not made when due;
3. the enrollee becomes covered under another group dental plan, unless the new plan covering the enrollee contains a preexisting condition exclusion or limitation that applies to the enrollee (in which case COBRA coverage will cease on the earlier of (a) the end of the COBRA continuation period, or (b) the cessation of the application of the preexisting condition exclusion); or
5. the former employer ceases to offer group dental coverage.

EXTENSION OF BENEFITS FOR COVERED RETIREE DEPENDENTS NOT ELIGIBLE FOR COBRA

The following dependents may continue PEBB coverage for up to a total of 36 consecutive months if they lose PEBB coverage due to: (a) termination of a qualified domestic partnership or (b) loss of dependent child eligibility

- Qualified domestic partner.
- Children eligible through a qualified domestic partnership.\

When an event ends eligibility for coverage, the enrollee must contact the HCA within 60 days of the qualifying event for information about the right to an extension of coverage and self-pay premium rates. Enrollees are required to pay their own premium, which begins accruing the first day of the month following the qualifying event. Failure to notify the HCA will result in the loss of continuation rights.

RELEASE OF INFORMATION

Enrollees may be required to provide the Uniform Dental Plan or the HCA with information necessary to determine eligibility, administer benefits or process claims. This could include, but is not limited to, dental records. Coverage could be denied if enrollees fail to provide such information when requested.

THIRD PARTY LIABILITY
(SUBROGATION/REIMBURSEMENT)

Benefits of the Uniform Dental Plan will be available to an enrollee who is injured or becomes ill because of a third party's action or omission. The Uniform Dental Plan shall be subrogated to the rights of the enrollee against any third party liable for the illness or injury. Subrogation means that the Uniform Dental Plan (1) shall be entitled to reimbursement from any recovery by the enrollee from the liable third party, and (2) shall have the right to pursue claims for damages from the party liable for the injury or illness. The Uniform Dental Plan's subrogation rights shall extend to the full amount of benefits paid by the Uniform Dental Plan for such an illness or injury. As a condition of receiving benefits for such an illness or injury, the enrollee, and his or her representatives, shall cooperate fully with the Uniform Dental Plan in recovering the amounts it has paid including, but not limited to: (a) providing information to the Uniform Dental Plan concerning the facts of the illness or injury and the identity and address of the third party or parties who may be liable for the illness or injury, their liability insurers, and their attorneys; (b) providing reasonable advance notice to the Uniform Dental Plan of any trial or other hearing, or any intended settlement, or a claim against any such third party; and (c) repaying the Uniform Dental Plan from the proceeds of any recovery from or on behalf of any such third party.

Enrollee's Obligation to Notify the Uniform Dental Plan

Enrollees must notify the Uniform Dental Plan of any claim or lawsuit for a condition or injury for which the Uniform Dental Plan paid benefits. This includes promptly notifying the Uniform Dental Plan in writing of all the following matters:

- the facts of the enrollee's condition or injury,
- any changes in the enrollee's condition or injury,
- the name of any person responsible for the enrollee's condition or injury and that person's insurance carrier, and
- advance notice of any settlement the enrollee intends to make of the action or claim.

Right of Recovery

If an enrollee brings a claim or lawsuit against another person, the enrollee must also seek recovery of any benefits paid under this plan; the Uniform Dental Plan reserves the right to join as a party in any lawsuit the enrollee brings. The Uniform Dental Plan may, however, assert a right to recover benefits directly from the other person or from the enrollee. If the Uniform Dental Plan does so, the enrollee does not need to take any action on behalf of the Uniform Dental Plan. The enrollee must, however, do nothing to impede the Uniform Dental Plan's right of recovery. Should the Uniform Dental Plan assert its right of recovery directly, it has the right to join the enrollee as a party in the action or claim.

If the enrollee obtains a settlement or recovery for less than the insurance policy limits or reachable assets of the liable party, the enrollee is obligated to reimburse the Uniform Dental Plan for the full amount of benefits paid on the enrollee's behalf. If, however, the enrollee obtains a settlement or recovery that is equal to or greater than the liable party's insurance policy limits or assets, the enrollee is only obligated to reimburse the Uniform Dental Plan in the amount that is left after the enrollee has been fully compensated.

Any person who is obligated to pay for services or supplies for which benefits have been paid by the Uniform Dental Plan must pay to the Uniform Dental Plan the amounts to which the Uniform Dental Plan is entitled.

COORDINATION/NON-DUPLICATION OF BENEFITS

The UDP will coordinate benefit payments with any other group dental plan, Medicaid and Workers' Compensation plan which covers the enrollee. Benefit payments will not be coordinated with any individual coverage the enrollee has purchased.

If the enrollee is covered by more than one group dental insurance plan, please submit claims to WDS and the other carriers at the same time. This helps to coordinate benefits more quickly.

The plan that is to provide benefits first will do so for all the expenses allowed under its coverage. The other plan will then provide benefits for the remaining allowed expenses.

The UDP employs a coordination of benefits method known as nonduplication of benefits when it is secondary to another group plan. This means that when the UDP is secondary it will pay no more than the amount it would have paid if it were the primary plan, minus what the primary plan has paid.

When another governmental program of health care coverage is one of the plans, federal law determines which plan provides benefits first. Otherwise, the following rules determine which plan provides benefits first:

1. When both plans coordinate benefits, the plan covering the person as a subscriber provides benefits first.

2. Dependent children are covered first under the plan of the parent whose birthday is earlier in the calendar year. If the parents are divorced or separated, the following rules determine which plan pays first:

    a. Plan of the parent with custody.
    b. Plan of the spouse of the parent with custody.
    c. Plan of the parent without custody.
    d. Plan of the spouse of the parent without custody.

    If there is a court decree which establishes responsibility for the child's health care, the plan of the parent with that responsibility provides benefits first.

3. If none of these rules establishes which plan provides benefits first:

    a. The plan that has covered the enrollee the longest time provides benefits first.
    b. All other plans provide benefits first if the person is a retiree, a laid-off employee, or a dependent of a person who is retired or laid-off if the other plans include this rule.

4. When none of the above rules establish the order of benefits, then the plan that has covered a subscriber for the longer period of time will provide benefits first.

The two examples that follow explain how nonduplication of benefits works:

Example 1: Assume a subscriber has satisfied the deductible on both the primary dental plan and the UDP. The individual receives services for a root canal (Class II benefit) that costs $350. The primary plan pays Class II benefits at 90% and would pay $315 ($350 x 90%). The UDP pays Class II services at 80% and would have paid $280 ($350 x 80%) if it were primary. As secondary payer, the UDP subtracts what the primary payer paid and pays the difference ($280 - $315 = $0 payment).

Example 2: Assume the primary plan pays 50% for Class II benefits. The primary plan would pay $175 ($350 x 50%) for the root canal described in Example 1. As secondary payer, the UDP would pay $105 ($280 - $175).

CLAIM REVIEW AND APPEAL

Initial Claims/Benefit Determination

An initial claim determination will be performed on all properly submitted claims within 30 days of receipt. The 30-day period may be extended for an additional 15 days, however, if the claim determination is delayed for reasons beyond our control. In that case, we will notify the subscriber prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from the subscriber, the notice will describe the specific information we need, and the subscriber will have 45 days from the receipt of the notice to provide the information. Without complete information, the subscriber claim will be denied.

If a claim is denied, in whole or in part, the Eligible Person will be furnished with a written notice of an adverse benefit determination that will include:

- the specific reason or reasons for the denial,
- reference to the specific plan provision on which the denial is based,
- a description of any additional material or information necessary for the Eligible Person to complete the claim and an explanation of why such material or information is necessary to process the claim, and
- the appropriate information as to the steps to be taken if the Eligible Person wishes to appeal the decision.

Predetermination/Claims

Predetermination or claims require notification or approval prior to receiving dental care. The claims administrator will provide notice of the claim decision within 15 days after receiving the claim. If a predetermination is filed improperly, the claims administrator will provide notification of the improper filing and how to correct the filing within 5 days after receipt of the predetermination. If additional information is required, the claims administrator will notify the Eligible Person of what information is needed within 15 days after the claim is received. The claims administrator may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension the Eligible Person has 45 days to provide this information. Once the information is received the claims administrator will make a determination within 15 days. If the information is not provided within 45 days, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claim Review

Dental benefit coverage typically does not require urgent claim review. Urgent care claims require notification or approval prior to receiving dental care when a delay in treatment could seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician who has knowledge of the medical condition or a dentist who has knowledge of the dental condition. These are rare dental situations and require determination by a physician or dentist with knowledge of the condition.

WDS will provide notice of the benefit determination, in writing or electronically, within 72-hours after receipt of all necessary information. When practical, WDS may provide notice of denial orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain prior authorization in an emergency. The claim will be evaluated after treatment. The Eligible Person or the dental office may obtain information regarding covered benefits anytime prior to treatment.

If an urgent care claim is filed improperly, WDS will notify the Eligible Person within 24 hours along with instructions on how to file properly. If additional information is needed to process the claim, the Eligible Person will be notified of the information needed within 24 hours after the claim is received. The Eligible Person then has 48 hours to provide the requested information.

WDS will notify the Eligible Person of the determination no later than 48 hours after receipt of the requested information or at the end of the 48-hour period within which the Eligible Person was to provide the additional information.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Appeals

Should a claim be denied, in whole or in part, the Eligible Person has a right to a full and fair review. The request to have a denied claim reviewed must be in writing and must be submitted within 180 days from the date the claim was denied. Further consideration will not be allowed after 180 days.

A final benefit determination will be made within 60 days following receipt of an appeal.

An appeal must include name, identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits.

Send your appeal to:

Washington Dental Services
Appeals/Customer Service
Post Office Box 75688
Seattle, WA 98125-0688

Written comments, documents, or other information may be submitted in support of an appeal. Upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision will be provided. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any consideration.

The review will be conducted by someone different from the original decision-makers and without deference to the initial decision. If the appeal is based in whole or in part on a medical judgment including a determination as to whether a particular treatment, drug or other item is experimental, investigational, or not dentally necessary or appropriate, WDS will consult with a dental professional who has appropriate training and experience. In such a case, the professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any expert whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination.

APPEALS PROCEDURE

If you feel that you have been wrongly denied benefits, have had a claim processed incorrectly or have some other complaint; you should first contact the Uniform Dental Plan Customer Service Department. The number is 1-800-537-3406 or 206-522-3344 (Seattle). A WDS dental consultant will review your appeal.

If the problem is not resolved to your satisfaction, you may ask for review by the Appeals Coordinator of the Health Care Authority within 30 days of the denial by the Uniform Dental Plan. Your request for reconsideration must be in writing and must include all documentation or information that you believe supports your reconsideration request. Any information or documentation submitted at a later date may not be considered in formulating the appeal decision. A written response will be provided to you within 30 working days of the HCA's receipt of the written request for reconsideration.

If the reconsideration by the Appeals Coordinator of the Health Care Authority upholds the denial, you may appeal the decision by filing a written request with the Washington State Health Care Authority Appeals Committee, 676 Woodland Square Loop SE, PO Box 42684, Olympia, Washington 98504-2684. The request must be received by the Health Care Authority within 60 days of the decision by the Appeals Coordinator. The request must contain:

1. the name and address of the enrollee;
2. the name and address of the appealing party;
3. a statement identifying the specific portion of the decision being appealed, making it clear what it is that is believed to be unlawful or unjust;
4. a clear and concise statement of facts supporting the appeal;
5. any and all information or documentation that you would like considered and that you feel substantiates why the claim or request for coverage should be covered (**Information or documentation submitted at a later date may not be considered in the appeal decision.**).
6. relief sought; and
7. a copy of the Uniform Dental Plan's response to the issue you have raised.

If the Appeals Committee upholds the original denial, you may request a hearing by writing to the Communication and Appeals manager of the Health Care Authority. The Health Care Authority must receive the written request for hearing within 15 days from receipt of the Appeals Committee's final decision. All participating parties have at least seven days notice of the hearing date. The Health Care Authority Administrator or designee will preside at the hearing, which will be conducted in accordance with applicable state rules. After hearing, the agency's final decision will be sent to all parties.

Predetermination Appeals

If a predetermination is required by WDS or is requested by an Eligible Person, or his/her designee and an adverse decision is rendered, any person aggrieved thereby shall have the right to appeal the same to WDS in writing. In the event of such an appeal, the question will be re-evaluated and communicated to the appealing party within 15 days by the Dental Director, or his/her designee, unless WDS notifies the aggrieved person that an extension is necessary, in which case the decision shall be communicated within 30 days absent informed, written consent of the aggrieved person for a longer extension. An appeal shall be evaluated by a dentist who was not involved in the decision which is the subject of the appeal.

Authorized Representative

Eligible Person may authorize another person to represent them and with whom they want WDS to communicate regarding specific claims or an appeal. The authorization must be in writing, signed by Eligible Person, and include all the information required in an appeal. (An assignment of benefits, release of information, or other similar form that Eligible Person may sign at the request of their health care provider does not make your provider an authorized representative.) You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

DISCLOSURE INFORMATION

In accordance with section 4 of ESSB 6392, Chapter 312, Laws of 1996, the Managed Care Entities Disclosure Act, WDS is pleased to provide important information about our various dental care plans. The goal of this new law is to provide individuals who are making health care decisions for themselves and their families with as much information as possible to make the best decisions. Washington Dental Service fully supports this principle and supplies most of the required information in enrollee benefit booklets, which are supplied to each enrollee at the start of their coverage.

The items of information which you may request Washington Dental Service to provide you are:

1a) the availability of a point of service plan and how the plan operates within the coverage

1b) documents, instruments or other information referred to in the enrollment agreement

1c) procedures to be followed for consulting a provider other than the primary care provider (applies primarily to capitation plans)

1d) existence of plan list or formulary for prescription drugs, for plans with that specific benefit

1e) procedures that must be followed for obtaining prior authorization for health care services

1f) reimbursement or payment arrangements, between a carrier and a provider

1g) circumstances under which a plan may retrospectively deny coverage for care that had prior authorization

1h) copy of all grievance procedures for claim or service denial and for dissatisfaction with care

1i) description and justification for provider compensation programs, including any incentive or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists

2) Enrollees of Washington Dental Service dental care plans may, at any time, freely contract to obtain other forms of dental care or health care services outside Washington Dental Service plan coverage for any reason they choose, however, the enrollee must pay for all such services.

Washington Dental Service

Subscriber Rights and Responsibilities

At Washington Dental Service our mission is to provide quality dental benefit products to employers and employees throughout Washington through a network of over 2,900 participating dentists.

We view our benefit packages as a partnership between Washington Dental Service, our subscribers and our participating members' dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You have the right to:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta member / non-member), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact Washington Dental Service customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at deltadentalwa.com
- Appeal in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To receive the best oral health care possible, it is your responsibility to:

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents which you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to Washington Dental Service to assist with the processing of claims.
- If applicable, pay the dental office the appropriate co-payments amount at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.
- Inform your dentist and your employer promptly of any change to your or a family member's address, telephone, or family status.